PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

State of New Jersey
Department of Human Services
Office of Program Integrity and Accountability
P.O. Box 700
Trenton, NJ 08625-0700

SARAH ADELMAN
Commissioner

DEBORAH ROBINSON
Director

FINAL AGENCY DECISION
OAL DKT. NO. HSL 07836-20
AGENCY DKT. NO. DRA 20-008

T.M.,

Petitioner.

v.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

T.M., pro se

Michael R. Sarno, Deputy Attorney General, for respondent (Matthew J. Platkin, Attorney General of New Jersey, attorney)

Record Closed: June 27, 2023 Decided: August 9, 2023

BEFORE **ELAINE B. FRICK**, ALJ:

INITIAL DECISION

STATEMENT OF THE CASE

Respondent, New Jersey Department of Human Services (DHS) seeks to place petitioner, T.M.'s name on the Central Registry of Offenders against Individuals with Developmental Disabilities (Central Registry) due to alleged physical abuse of a developmentally disabled

individual. Petitioner appealed, asserting he should not be placed on the Central Registry.

PROCEDURAL HISTORY

The Department notified petitioner his name was being placed on the Central Registry by letter dated June 4, 2020. Petitioner requested an appeal. The matter was transmitted to the Office of Administrative Law (OAL) where it was filed on August 19, 2020, to be heard as a contested matter. N.J.S.A. 52:14B-1 to 14B-15; N.J.S.A. 52:14F-1 to 14F-13. An Order to Seal was entered on October 29, 2020.

The matter was docketed at the OAL in the midst of the COVID pandemic. Multiple pre-hearing telephonic conferences were scheduled and conducted with the parties, or adjourned at the request of the parties. Discovery schedules were set and adjusted at the request of the parties. As of July 12, 2021, the matter was considered abandoned as petitioner failed to appear for a telephonic conference, and the file was to be closed. Petitioner communicated that he experienced personal issues and COVID related matters in his life, and did intend to proceed with this appeal. The matter remained active and additional pre-hearing telephonic conferences were conducted. Discovery issues were discussed and resolved during such conferences. Discovery was reported as being completed and the parties were going to engage in settlement discussions.

Hearing dates were scheduled. The parties agreed and requested to conduct the hearing as a Zoom proceeding. A Pre-Hearing Order was entered on April 5, 2022. An Amended Pre-Hearing Order was entered on August 4, 2022. The hearing dates were adjourned due to conflicting matters arising on the OAL calendar. The proceedings were rescheduled. Petitioner failed to appear for a final pre-hearing telephonic conference which was scheduled in advance of the hearing dates. The hearing dates remained as scheduled, and a Second Amended Pre-Hearing Order was entered on February 10, 2023, reconfirming the hearing dates.

The hearing was conducted via Zoom audio video technology on March 24, 2023. The record remained open for the submission of written summations. Respondent's summation was submitted as scheduled. The record remained open to permit additional time for petitioner to submit a written summation. Petitioner did not submit a written summation, and the record was closed on June 27, 2023.

FACTUAL DISCUSSION AND FINDINGS

Information was derived from the testimony of witnesses and evidence, which was undisputed. The Administrative Law Judge (ALJ) **FOUND** as **FACTS** the following:

- T.M. was employed as a community support staff (CSS) member by Heart to Heart, a company which operates group homes that provide housing for developmentally disabled individuals. K.S. is a developmentally disabled individual. He was a resident (also referred to as a serviced client, consumer, or service recipient) at a group home operated by Heart to Heart in Clayton, New Jersey.
- T.M. worked for Heart to Heart at another location for approximately one year prior to the incident in question. He began working at the Clayton location, where K.S. was a

resident, in approximately September 2018. K.S. was one of the residents T.M. was assigned to assist as a CSS.

- K.S. was known to elope. He was known to get frustrated over issues and call 911 or visit the hospital. For example, he was not permitted to smoke after 10:00 p.m. On one occasion in May 2019, K.S. was discharged from the hospital after 10:00 p.m. When K.S. returned to the residence, he was not permitted to smoke and he "flew off of the handle" and "ran away" with the staff following behind him in a truck. (R-18 at 3.) K.S. refused to get in the truck. The police were called and K.S. returned to the residence with them without further incident that evening. (R-18 at 3.)
- On September 1, 2019, T.M. was one of the staff members who accompanied other residents on an outing, off the residential premises. K.S. did not go on the outing. T.M. returned to the facility in the early evening with the other residents from the outing. He went to check on K.S. and K.S. was not in his room. T.M. began looking for K.S., and learned from another staff member that K.S. apparently had gone to another resident's room, in a different building, to obtain a cigarette. T.M. went to that room and K.S. was not there.
- T.M. and a member of the home's management staff, T.H.J., went to look for K.S. in the community. T.H.J. was driving a black sport utility vehicle (SUV). T.M. was in the vehicle as a passenger. As they drove on North Delsea Drive in Clayton, they saw K.S. walking on the sidewalk. T.M. exited the van and had an interaction with K.S.
- A surveillance video camera from a local resident/business operator, D.G., recorded the interaction of T.M. and K.S. next to D.G.'s business. D.G. saw the interaction on the video, and called the local police department the following morning, to report her concern that someone might have been reported missing. Her video was recorded by a member of the Clayton Police Department while viewing the video as it was played on D.G.'s cell phone. A text message alert on D.G.'s cell phone drops down over the top of the video as it was being recorded by the officer. (R-1.)
- The recorded video tape clip is approximately two minutes and forty-five seconds. The parties stipulated that the date of September 2, 2019, which appears date stamped on the video is incorrect and should be September 1, 2019. There is no audio of the video altercation. (R-1.) The view is from above, on an angle, showing K.S. walking briskly from the bottom of the screen, towards the top of the screen viewpoint, walking on the sidewalk in front of the business. A black SUV pulls up along the curb with the passenger side of the vehicle along the sidewalk area. T.M. is seen exiting the SUV and rapidly approaches K.S., walking alongside him, then K.S. backs up towards the building, with T.M. approaching K.S., which is partially obscured by the steps of the business. (R-1 at 0:13.) T.H.J. comes around from the rear of the vehicle towards the two men and walks up closely to K.S. and gestures with her left arm towards the SUV.
- K.S. backs away from T.M. and T.H.J., shifting to his right and grasps onto the stairway railing. (R-1 at 0:28.) T.H.J. walks back to the SUV. (R-1 at 0:42.) T.M. and K.S. both have their backs to the building wall, then T.M. comes around to the front of K.S., appearing to be speaking/talking to K.S., making gestures with his hands, and then reaches towards K.S.'s right hand/right pants pocket. T.H.J. is backing the SUV up, which has the front passenger door still open from when T.M. had exited the vehicle. (R-1 at 0:57.)

- T.M. moves around K.S., to K.S.'s left side, still appearing to be talking to K.S., and making gestures with his hands. T.H.J. gets out of the SUV and walks around the rear of the vehicle, onto the sidewalk area, and opens the rear passenger door. T.M. steps back away from K.S. (R-1 at 1:19.) T.M. and T.H.J. then both approach K.S. and both appear to tap or touch K.S.'s left pocket area. (R-1 at 1:25.) They appear to be conversing with K.S., with T.M. pacing backwards briefly then approaching K.S. again closely. (R-1 at 2:03.)
- K.S. then stretches out his left hand and appears to contact T.M. in the chest and pushes T.M. back. T.M. immediately steps forward and appears to grab K.S.'s left arm, which is obstructed in the view from the camera angle. (R-1 at 2:09 – 2:10.) K.S. swings his right arm towards T.M., and the two men scuffle together. T.M. appears to keep his grasp on K.S.'s left arm while K.S. swings his right arm towards T.M., who then appears to punch with his right arm swinging towards K.S. (R-1 at 2:14.) T.H.J. stands by watching the men.
- T.M. puts his hands near K.S.'s waist while K.S. is swinging and the men shift positions and T.M. pushes K.S. back. K.S. stumbles backwards and T.M. again pushes K.S. in the chest, pushing him back as K.S. flails his arms backwards. (R-1 at 2:30.) T.M. then grabs and pushes K.S. towards the open back passenger car door and shoves K.S.into the back seat. (R-1 at 2:30.) K.S. is shoved in facing forward into the back seat and his right arm is seen to stretch up and his inner arm strikes the exterior top of the door frame. (R-1 at 2:32.) T.M. struggles pushing K.S. into the back seat while T.H.J. comes up from behind T.M. and reaches her left hand around T.M.'s left side. T.M. continues to struggle with K.S., who is inside of the vehicle. (R-1 at 2:42.) T.M. then slams the back passenger door shut. T.H.J. goes around behind the vehicle and T.M. walks to the open front passenger side door. (R-1 at 2:43.) The video clip ends at two minutes forty-seven seconds. (R-1.)

Testimony at Hearing

For Respondent

Rosa Gonzalez (Gonzalez) testified. She is retired from the Department of HumanServices (DHS), Office of Investigations. At the time of her retirement from DHS, she was a quality assurance specialist, also referred to as an Office of Investigations (OI) investigator. She held that position for the ten years of her approximately thirty-five-year employment with DHS.

As an OI investigator, her main job responsibility was to investigate allegations of neglect, physical or verbal abuse, and allegations of exploitation of individuals with developmental disabilities. She had to determine if alleged incidents had occurred and determine if the allegations of neglect or abuse were substantiated. She conducted hundreds of investigations during her time as an OI investigator, and interviewed hundreds of individuals with developmental disabilities.

Only a low percentage of the matters she investigated resulted in the substantiation of abuse or neglect. If she determined that the allegation was substantiated, her investigation findings would be reviewed by a supervisor. At some point thereafter, DHS would confirm if the offender would be placed on the registry.

She was the primary investigator of the allegation of physical abuse of K.S. by T.M., and allegations of neglect of K.S. by another staff member, C.S., and staff administrator, T.H.J.

Gonzalez was assigned the matter by receipt of an email, approximately two days after the incident. She conducted interviews, obtained and reviewed documentation, photographs, and video, and then authored an investigation report. (R-4.) Gonzalez determined that the incident occurred on September 1, 2019, on North Delsea Drive in Clayton, at approximately 7:30 p.m. T.M. was employed by Heart to Heart as a CSS, at the location where K.S. was a resident.

Gonzalez interviewed, K.S., who was able to verbally communicate, on September 23, 2019. She interviewed him at the group home residence. K.S. advised Gonzalez that T.M. pushed and hit him, and T.M. threw K.S. into a car. (R-4 at 8.) She testified she thought K.S. told her that when he was thrown into the car, he hit his face or head on the door jamb. She did not believe K.S. stated during his interview that anything happened to him while in the car. He conveyed to her everything that had happened before he was thrown into the car.

She reported that K.S. told her that he and T.M. "got in a fist argument" which he explained meant that he was punched by T.M. (R-4 at 8.) She noted in her report that K.S. indicated he was punched by T.M. once in the face and was pushed by T.M. hard enough to make him stumble backward. She indicated in her report that K.S. stated T.M. "Physically picked me up and threw me in the car." (R-4 at 8.) He reported hitting his head on the car. He denied that anything physical occurred in the car on the ride back to the residence. He did not tell anyone what occurred that evening. After the police came the next day to see him, K.S. told N.C., the group home manager, what had occurred. (R-4 at 8.)

Gonzalez recalled that during the interview she observed K.S. to have marks on his forearms. She recalled seeing photographs with marks on his face but could not specifically recall during her testimony if she observed the face markings during her interview with him. K.S. told Gonzalez during the interview that when he got back to the residence, he had injuries to his forearms and right eye. (R-4 at 8.) He told her that the police had taken photographs of his injuries.

Gonzalez communicated with members of the Clayton Police Department and obtained documentation. She spoke with Officer Martines, who allowed her to watch the video of the incident and look at the photographs a member of the police department had taken of K.S. depicting the markings on his arms and face. (R-1, R-5.) She believed the photographs were taken the day after the incident, on September 2, 2019. To her knowledge, the markings were caused to K.S. by T.M., after their physical interaction on September 1, 2019. The markings she viewed in the photographs were consistent with the information K.S. provided to her during the interview, as to how the incident occurred and the injuries he sustained to his face, eye, and arms.

The police report prepared by Officer Martines on September 2, 2019, was provided to Gonzales, and included as part of her report. (R-6, R-5.) She found the version of events K.S. described to the police, as recorded in the report, was consistent with the information he told her during his interview. (R-6 at 2-3.) She also received a taped interview of K.S. which was done by the Clayton Police Department. She confirmed that K.S. was the individual depicted in the video and confirmed that he stated to the police that he was struck by T.M. three times. (R-21.)

The group home manager, N.C., was also interviewed by Gonzalez as part of her investigation. N.C. had seen K.S. the day after the incident. The information N.C. told Gonzalez was consistent with the photographs Gonzalez viewed of the markings and injuries to K.S. (R-4 at 10–13.)

On September 25, 2019, Gonzalez interviewed T.M. in person. (R-4 at 24–28.) She recalled that T.M. described that there was an outing he had been on for the home, and when he returned, it was discovered that K.S. had left the home. T.M. and the administrator, T.H.J. went to look for K.S. They found him walking on the sidewalk along Delsea Drive. T.M. described

during the interview that he put K.S. in a bear hug and put him in the car. He did not mention during the interview that he had struck K.S. He did mention that he pushed K.S. He admitted that he did not document the incident and believed that T.H.J. had done so. He admitted he had been trained prior to the incident regarding the prevention of abuse, neglect and exploitation of developmentally disabled individuals.

Gonzalez viewed the video tape of the incident with T.M. during her interview with him. (R-1.) He confirmed he was the African American man in the white shirt seen in the video. He confirmed K.S. was the Caucasian male. He confirmed the video accurately depicted the incident.

Before Gonzalez started the interview, T.M. signed the Interviewee Summary Form, which is given to the individual being interviewed as part of her investigation. It explains rights and responsibilities with regard to the investigation and the confidentiality of the investigation. (R-9 at 1–2.) T.M. filled out the form and signed it on September 25, 2019. (R-9 at 2.) Gonzalez wrote in her initials, R.G., on the line over "ID Verified" on the form. (R-9 at 2.) After she was done asking him questions, he handwrote a statement then, signed it, and Gonzalez signed it. (R-9 at 3–4.) T.M. wrote in his statement that he did not physically abuse K.S. (R-9 at 4.) He wrote that he did not assault K.S. anytime and never verbally abused him. (R-9 at 4.)

Gonzalez denied that she told T.M. during his interview that he would not be placed on the Central Registry. She denied ever stating there were worse cases than this one and denied that she told him he would not be placed on the Central Registry. She never conveyed to T.M. during the interview that she agreed he was being threatened by K.S.

Gonzalez interviewed six other staff members on October 7, 2019, from the residence. None of them witnessed the incident and did not provide any relevant information. (R-4 at 39–40.) She also interviewed T.H.J. who did not mention during the interview that T.M. had shoved or pushed K.S. (R-4 at 29–34.) T.H.J. stated that K.S. punched T.M. and T.M. put his arms around K.S.'s body and arms and they walked toward the car and got into the back seat of the vehicle. (R-4 at 32.) Gonzalez watched the video with T.H.J. and T.H.J. identified herself and T.M. in the video. (R-1.) T.H.J. commented that the video "looked bad." (R-4 at 34.) She denied that T.M. physically abused K.S. and that T.M. was advocating for K.S. and attempting to redirect him into the car. (R-4 at 34.)

Gonzalez gathered and reviewed documentation as part of her investigation. She obtained and reviewed K.S.'s individualized service plan (ISP), which provides background information on the individual with developmental disabilities, diagnoses, and behaviors. (R-19.) The plan was printed on May 19, 2019, approximately four months prior to the incident. She saw in the ISP that K.S. engaged in elopement by walking away from the home. She understood that the ISP was shared with K.S.'s caretakers, including T.M. She saw that K.S. did not have a behavioral plan, but that was a concern to be addressed.

T.M.'s training records were obtained by Gonzalez. (R-15.) She needed to verify whether T.M. had received training regarding the law prohibiting and preventing abuse and neglect, and other trainings that are required for staff members. (R-15.) She determined upon review of the records that T.M. received proper training from Heart to Heart. The last time he had obtained training to prevent abuse, neglect, and exploitation was September 19, 2018, according to the documents. (R-15.) She was not aware of any training T.M. would have received, which would permit him to push a service recipient or throw an individual into a car.

Gonzalez obtained a copy of the Heart to Heart policy and procedure manual, regarding reportable incidents. (R-8.) This was relevant to her investigation since the incident was one that was considered reportable, and T.M. did not report it.

Gonzalez obtained and reviewed the Support Coordinator Monitoring Tool document for K.S. (R-18.) It is a document completed by support coordinators, individuals who complete monthly reviews of serviced clients. (R-18.) If a reportable incident has occurred, it is documented in the monitoring tool. When she obtained the document, she saw that the incident was not reported. The monitoring tool document is dated August 27, 2019. (R-18.)

Heart to Heart maintains daily logs for service recipients. Gonzalez obtained the daily log for K.S. (R-14.) The one page of the daily log sheet covers the dates of September 1, 2019, through September 5, 2019. There is an entry on September 1, 2019, that K.S. came home from the hospital at 8:57 a.m. and some entries thereafter regarding his medications. There is no entry for the actual incident of September 1, 2019.(R-14.) There should have been an entry about the physical contact between T.M. and K.S. on that date.

A Body Check Form was completed by someone from Heart to Heart for K.S. on September 2, 2019. (R-13.) The document confirmed there were noticeable marks on his arms. Gonzalez found this information consistent with the interviews she had conducted regarding K.S.'s condition after the incident, and the photographs she had reviewed.

The hospital records for K.S.'s treatment at the emergency room on September 2. 2019, were obtained by Gonzalez. She saw that the records noted K.S. reported being assaulted, punched in the face, and his arms were grabbed. (R-11.) Ecchymosis was noted to be present on his neck, his right eye, and his forearms had hematomas. (R-11.)Gonzalez saw that the injuries observed were noted to have been as a result of the incident with T.M. This information was consistent with the interviews she conducted, the documents she reviewed, and the photographs that were taken by the police on September 2, 2019. She believed that the markings on K.S.'s arms and face were consistent with having been caused by the physical interactions between T.M. and K.S.

Gonzalez reviewed the video of the incident many times. She provided an analysis in her written report. (R-4 at 40–41.) She acknowledged that K.S. made physical contact with T.M. first. She considered that in her investigation. She also counted at least three times towards the end of the video clip seeing T.M. push K.S. She found T.M.'s actions to be aggressive and abusive. It did not appear that K.S. was doing anything physically back to T.M. after T.M. would push K.S. She thought it was fair to say T.M. engaged in unprovoked pushes at the end of the video clip, which substantiates the allegation of abuse. T.M. then aggressively put his arms around K.S. and shoved K.S. into the car. That is what T.M. referred to in his interview as a bear hug. There is additional shoving of K.S. by T.M., after T.M. shoved K.S. into the car. She thought this was relevant, since the physical actions seen on the video were consistent with K.S.'s report of the incident and the injuries he sustained. Even if K.S. was threatening to hurt T.M., T.M. was not permitted to push K.S. or to engage K.S. in a bear hug, physical hold, or restraint. She did not find that T.M.'s actions towards K.S. were justified in any way by any regulations, policies, or training T.M. had received. The video substantiated that T.M. physically abused K.S.

Based upon her interviews, document review, review of photographs, and review of the video, Gonzalez concluded that the allegation of physical abuse of K.S. by T.M. was substantiated. She determined it was physical abuse, with minor injuries. Substantiated abuse means that the evidence preponderates that the incident occurred and caused the abuse and injury.

Gonzalez later learned that DHS notified T.M. of its intent to place his name on the Central Registry of Offenders against Individuals with Developmental Disabilities. (R-3.) A letter issued on June 4, 2020, from Lauri Woodward, Director of the Office of Program Integrity and

Accountability for DHS to T.M., confirming this information. (R-3.)

William Pauley (Pauley) testified. He is the business director for Heart to Heart. He has been employed by Heart to Heart for nine years, having been a group home manager, regional director, and now serving as the business director since 2019. He confirmed that Heart to Heart provides residential and community residential treatment for people with intellectual and developmental disabilities.

During his employment with Heart to Heart, he has participated in, and supervised new hire orientation training. He has handled new employee on-boarding and supervisedor conducted mandated training, such as preventing abuse and neglect and exploitation (PANE) of individuals with developmental disabilities. Employees also receive training after their new hire orientation, some such training being mandated every year. Some of the training curriculum is standard, such as in the PANE training there is a competency assessment used, to confirm staff members have an understanding as to what abuse, neglect, and exploitation are and that staff can independently identify them and differentiate between them.

Pauley explained there are five types of abuse, and the mandated training for employees includes how to identify the abuse, how to handle situations when abuse is believed to have occurred, and the reporting procedures that are required. One type of abuse is physical abuse. During the training, employees are informed in general about working with individuals with developmental disabilities and informing the employees that some service recipients may demonstrate certain behaviors.

Service recipients may be identified as having elopement issues. Elopement is when an individual leaves a designated area without any supervision from a staff member. A walk-away is used to describe an individual who leaves a designated area, but a staff member is still maintaining supervision over the individual. Staff members are trained to maintain a level of supervision in the home and to follow the individual if it is possible and safe, if the individual walks away, to prevent elopement. If an individual escapes the view of a staff member who is trying to follow the individual, the staff member is supposed to call 911. The staff are trained on how to assess different situations as they arise, such as de-escalating someone who is upset or re-directing them.

The staff are never trained to use physical means to remedy an individual who is a walk-away or an elopement. Staff members are never permitted to use any type of physical means to return a service recipient who has eloped or walked away. Heart to Heart does train some staff members on acceptable or permitted physical restraints or holds. However, that is not permitted or authorized for the Heart to Heart program that was servicing K.S. If a service recipient has become combative with a staff member, the staff members are trained to remove other service recipients in the immediate vicinity, to prevent harm. The staff member is to remove himself from the area and call 911 when the individual poses a risk to themselves or other people. As of September 2019, staff members were never trained to push or bear hug a service recipient to calm the individual down.

Pauley was familiar with T.M. He knew him from seeing him at the workplace in the program where K.S. was serviced. Pauley knew T.M. to spend a lot of time at the program and he worked "a lot." He got along with T.M. and had a cordial working relationship. He identified T.M.'s training records, which confirm the training T.M. received. (R-15.)

Pauley was familiar with K.S. He confirmed K.S. has been a service recipient at Heart to Heart. He processed K.S.'s admission, moved him into the group home, and oversaw many of the services that K.S. received during his time with Heart to Heart. He described K.S. as a "jolly

fellow" who was a "good time" when he was having a good day. He would play basketball and go for walks, whether with or without permission. K.S. was very social and friendly to others in the community or in the program. K.S. was in the Clayton residence, which is a "hands off agency" for Heart to Heart. There are no kinds of physical restraints used on service recipients by staff members. K.S. had an ISP. (R-19.) The document governs and dictates how individuals are supposed to be serviced, including such things as routine hygiene and housekeeping and what level of assistance may be needed for the service recipient from a staff member. Employees and staff are provided access to the service recipient's ISP.

Pauley acknowledged that K.S. was known to elope from the group home from September 2018 through September 2019. He could not provide a rough estimate as to the number of times K.S. had eloped, yet noted sometimes he eloped three times a day. Pauley acknowledged it was very likely that T.M. was around for some of those incidents, but was unaware if T.M. had ever previously gotten into an altercation with K.S. Pauley recognized that K.S.'s incidents of elopement dramatically increased over the time he was in the group home. K.S. was there for at least three years. In the beginning he was not having so many incidents of such behavior, as when he did at the time he was later moved out of that group home and into a different program.

K.S. did not have a history of physical aggression, or behavioral acuity. Those individuals are not allowed to be placed in programs that are "hands off" because the State recognizes the need for critical intervention. Such individuals have routine and expected behavior of assaulting and attacking other people.

When questioned on cross-examination, Pauley was unaware of K.S. allegedly threatening someone who lived across the street from the home. He was unaware of any allegations of K.S. having pulled out a weapon on another consumer. Pauley vaguely recalled K.S. had trespassed onto a neighbor's property in the adjacent lake community, but did not recall the specifics of the incident. He recalled having to connect K.S. with legal representation for the matter, but did not recall the details of the matter.

T.M. was working for Heart to Heart as a CSS. The company has a job description for that position. (R-17.) On September 1, 2019, T.M. was scheduled to work the 3:00 p.m. to 11:00 p.m. shift. (R-12.)

Pauley confirmed that Heart to Heart has an employee corrective counseling form,which is used to document employee discipline. (R-16.) T.M. had an employee counseling form issued to him, and signed by T.M. on September 3, 2019, referencing an occurrence date of September 1, 2019. T.M. was suspended indefinitely for an allegation of physical assault and abuse. Typed in under the explanation of incident heading was "Heart to Heart received a report from DDD on 9/2/19 that you allegedly physically assaulted a service recipient from E. G. on the evening of 9/1/19. You were notified of this allegation on 9/2/19 and you were suspended from work on 9/2/19 pedning[sic] investigation of this matter." (R-16.) The form was prepared by the previous residential director for the agency at that time.

Pauley confirmed that the critical log is a document where staff are required to document critical information, as well as administration of medications, doctor appointments, and other routine goings on for serviced clients. The critical logs are not exclusive to one individual. The critical log sheet page for the September 1, 2019, date had entries for K.S. (R-14.) There were no entries referencing the interaction that occurred between T.M. and K.S. There were no entries indicating that K.S. had eloped and T.M. and T.H.J. drove off premises to find him and return K.S. to the group home.

Upon viewing the last portion of the video clip of the interaction between K.S. and T.M.

from September 1, 2019, Pauley confirmed that he saw what appeared to be an altercation between the men, and that T.M. shoved K.S. three or four times in an attempt to get K.S. into the vehicle. (R-1.) He saw that T.M. used a bear hug to put K.S. in the vehicle. None of the physical contact seen on the video is permitted to be done under Heart to Heart's policies. There was no such training provided to staff to engage in such physical contact or restraints with Heart to Heart service recipients.

For Petitioner

T.M. testified. He worked for Heart to Heart starting in 2016 or 2017, first with total care consumers, many who were bedridden, and he was tasked with bathing them and making sure they would get up. He started at the Clayton facility in 2018, and was there for about a year as of the date of the incident. He was CSS for K.S. and three other serviced clients.

He saw K.S. becoming a very, very, violent consumer. He got progressively worse, mostly with eloping, over the three years K.S. was at the group home, with T.M. seeing it for the year that he was there. He saw how K.S.'s behavior would become, such as when K.S. did not get things he wanted.

T.M. noticed that a lot of the escalating behavior from K.S. was from upper management, advising the CSS staff to tell things to K.S., causing K.S. to get an attitude and elope or walk away. At one time prior to the incident, the home manager, N.C., had told T.M. that she was not going to give K.S. anything to him on that day because K.S. told her that he was reporting they were stealing his money. T.M. said management was already in a "little altercation" and feeling like they were getting in trouble because K.S. would say that they were stealing money. N.C. had locked up K.S.'s cigarettes and went home for the weekend, having told K.S. he was not getting anything. This is a reason why a lot of K.S.'s behaviors happened. T.M. would have to be the one to deal with the circumstances as the "smallest" person in the organization with no power or no say in things. He told upper management multiple times, including N.C. and Pauley, about issues with K.S. They all understood that K.S. was becoming a bad individual.

Upper management would come down on the staff. They would tell the staff that certain individuals were not allowed to go to the hospital unless the complaint was chest or head pain. They would tell T.M. to not allow K.S. to "just keep running away for no reason." One night K.S. refused to take his medicine and went outside. The police were called. Three staff members were outside watching K.S., and he picked up a weapon and a police officer drew a gun on K.S. Initially, T.M. thought it was a Taser, and when he asked the officer if he really was going to Taser K.S., the officer told him he was going to shoot K.S. if he had approached the officer.

T.M. denied that physical restraints were never used at the group home. He personally witnessed a manager sit on a serviced client who had become combative. The individual flipped a table, flipped a chair, was throwing things, and the staff manager sat on him until the police came. He confirmed that Heart to Heart did have some programs where physical restraints were used. He acknowledged that the program in his group home did not allow physical restraints.

On the date of the incident, T.M. got back to the group home with the other residents after the outing. Management had told K.S. he was not allowed to attend the outing. When T.M. got to the home, he could not find K.S., asking the staff members who remained at the home where K.S. had gone. They did not know where he was, thinking he had gone to another room. When T.M. went to K.S.'s room and he was not there, T.M. immediately thought K.S. had eloped. He went to another resident's room, being advised K.S. had gone to ask for a cigarette from another

resident. The staff who had remained at the residence should have properly watched K.S. because he has twenty-four-hour supervision.

T.M. went with another staff member, T.H.J., to look for K.S. and found him. T.M. was talking to K.S., telling him he could not be doing this and to get into the car. K.S. got "mad and physically started smacking" T.M. (Trans 227:1-10.) K.S. was flailing his arms and hitting T.M., who grabbed K.S.'s arms. T.M. was never in a situation like that before.He knew he was supposed to make sure that K.S. did not go to the hospital if it is not needed. It was not necessary for K.S. to be going to the hospital so T.M.'s job was to make sure K.S. got back to the group home. T.M. denied that he was trying to harm or hurt K.S. He knew once K.S. was in a controlled setting he would be normal, good, and fine and would listen. T.M. testified that if he intended to harm K.S., he would have literally punched, kicked, and fought K.S. in some way. T.M. thought his actions in dealing with K.S. was doing something good for K.S., the home, and everyone involved, to get the situation under control. He thought he would try to restrain K.S. He knew it was not "100 percent how we're supposed to do [it]" but he was also told that if you are in a situation where restraint of a serviced client was necessary, they could talk about it, and he was only doing what he thought was right. (Trans 228:10–25.) He was told that if there was a cause to where you have to restrain someone that is what you do and talk about it after the fact.

T.M. testified he did push K.S. back because K.S. had first walked up on him. K.S. assaulted him first. When T.M. shoved K.S., he was thinking that he would restrain K.S. to get him into the car. He thought that would de-escalate the situation. He never intended, nor was he trying, to physically abuse K.S. in the middle of the street setting. He was trying to de-escalate the situation and end it without the police having to be called out. He recognized that pushing a service recipient is not a de-escalation tactic. However, he asserted that a bear hug can be a de-escalation tactic, if warranted. T.M. testified that the video demonstrates that while he was bear hugging K.S., K.S. was holding onto T.M.'s arms. He denied throwing K.S. into the vehicle, indicating he did "somewhat forcibly" put him in the car. He fell over top of K.S. while trying to get him into the car.

Once they got K.S. in the car, they drove home. During the ride, T.H.J. was talking to one of the staff members on speaker phone in the car. K.S. was still upset and saying things like he was going to punch a staff member when he got back to the home. They got to the home and there were a couple of staff members standing outside. K.S. got out and went upstairs to his room.

T.H.J., the assistant manager, was with T.M. She is the one who had direct contact with the manager, N.C. and called and text messaged with N.C. about the incident. That is why there is no paperwork. She was not asked for her text messages or to write a report. T.M. asserted that they were "calling, calling, calling" N.C. who was not answering her phone and they sent text messages back and forth with her.

Once back at the home, T.M. had to tend to his other consumers, because it was around 8:00 p.m., and that is the time medications must be administered. He tended to that. Others had to be showered, dishes had to be washed, and the house and bathrooms had to be cleaned. T.M. had to be sure all his consumers were good. When he went to give K.S. his medication, K.S. refused. T.M. admitted it is his handwriting on the critical log for the day, noting that K.S. refused his night time medication. (R-14.) With everything going on, T.M. accidentally did not write anything in the critical log about the incident in getting K.S. into the car and back to the home. He was not trying to hide anything. There was just so much going on after the incident that it slipped his mind. Management already was advised through his text messaging. T.M. acknowledged that this was

a reportable incident, and should have been reported.

T.M. was called the next day and told he was not allowed to return to the home, since there was an assault charge on him from K.S. Everything had to be taken care of before he could return. Heart to Heart was already moving forward to get rid of him, without an investigation being fully done. They were firing him, without a full investigation.

The investigation was a witch hunt because it should have shown that K.S. was becoming more combative. Heart to Heart should have moved K.S. out of the home. K.S. was becoming wilder, and then assaulted T.M., who now became the scapegoat due to Heart to Heart's failure to move K.S. The ISP for K.S. indicates that K.S. was to have behavior support. T.M. explained that a behaviorist is supposed to be on call, twenty-four hours, to be called when K.S. is having minor behaviors. That person is supposed to come in and handle the serviced client directly, hands on. T.M. testified that Heart to Heart never hired anybody for that. They did have one person, but that person was either fired or had quit.

T.M. went to municipal court for the assault charge. The whole case was dismissed. T.M. testified that he spoke to a police officer who was familiar with K.S. and was told that they understood what T.M. did and that he was "not totally wrong[.]" (Trans239:5–14.) T.M. asserted that the police did not want to go forward anymore with the charges.

He wound up taking "the whole fall and blame" for the situation when management was not doing what they should have been doing. T.M. was not afforded the proper help to fully take care of K.S. His pushing of K.S. did not result in any physical damage or harm to K.S.

T.M. just wants to clear his name. He is not trying to win anything going through this proceeding. He just does not want his name out there as abusing people with disabilities. He does not care about the Central Registry.

The ALJ's Finding of Facts

Based upon a review of evidence admitted during the hearing, and having had the opportunity to review the demeanor and observe the witnesses who testified during the proceeding, **The ALJ FOUND** as further **FACTS** the following:

T.M. received training by Heart to Heart on the topic of preventing abuse and neglect of developmentally disabled individuals. He was never trained to use physical restraints on serviced clients of the program. T.M. admitted he knew the program was a hands off residence for K.S.

T.M. engaged in physical interaction with K.S. on September 1, 2019. T.M. pushed and shoved K.S. towards the car, and grabbed him in a bear hug and forcibly pushed him into the car.

K.S. was interviewed by the police and by investigator Gonzalez. He provided consistent information that he was shoved and pushed by T.M. and forced into the car.

Photographs taken of K.S. by the police officer on September 2, 2019, while K.S. was at the police station to provide a statement to the officer, demonstrate bruising of K.S.'s right eye and inner forearms. (R-5.)

The emergency room records for K.S., where he was seen on September 2, 2019, indicate that upon physical examination, K.S. appeared "in mild pain distress" and had "[p]eriorbital ecchymosis present, to the right eye" and "[e]cchymosis present" of the neck and "[b]ilateral forearm hematomas." (R-11.)

A body check form completed by a Heart to Heart staff member on September 2, 2019, has handwritten in "9-2-19 to [sic] noticeable marks 1 on right arm 1 on left are marks look like brush burns light pink in color no other visible marks[.]" (R-13.)

The ALJ's Credibility Analysis

A fact finder is obligated to weigh the credibility of witnesses. The fact finder must choose to accept or reject whether a witnesses' testimony is credible. Freud v. Davis, 64 N.J. Super. 242, 246 (App. Div. 1960). Credibility is the value given to a witness' testimony. It is best described as that quality of testimony or evidence that makes it worthy of belief. "Testimony to be believed must not only proceed from the mouth of a credible witness but must be credible in itself. It must be such as the common experience and observations of mankind can approve as probable in the circumstances." In re Estate of Perrone, 5 N.J. 514, 522 (1950), (citations omitted).

A credibility determination requires an overall assessment of the witness' story "in light of its rationality or internal consistency and the manner in which it hangs together with other evidence." Carbo v. United States, 314 F.2d 718, 749 (9th Cir. 1963). The factfinder should also consider the witness' interest in the outcome, or any motive or bias. The fact finder may reject testimony because it is inherently incredible, improbable, inconsistent with common experience, contradicted by other testimony, or it is overborne by other testimony. Congleton v. Pura-Tex Stone Corp., 53 N.J. Super. 282, 287 (App. Div. 1958).

The witnesses for DHS testified in a professional and straightforward manner. There was no bias detected towards petitioner, nor any reason set forth to question the trustworthiness of the information provided.

T.M. was extremely passionate in his testimony and conduct. During the proceeding he would often interject, claiming he was being railroaded and that the witnesses were on the same team and against him. He became loud and expressive. He would get up and walk away from the camera. He would return on screen and express his frustration with the hearing process and assert that the witnesses were inaccurately or falsely portraying the circumstances of the situation during their testimony. His passion and frustration with his belief that upper management was unresponsive to complaints about K.S. was palpable. His explanation of the incident and description was in a manner of downplaying his actions, when viewing the actual video footage of the incident, which is understandable given his stake in the outcome of the proceeding. His fervent behavior during the proceeding was disruptive of the orderly flow of the proceeding, but he did not deny his actual actions as seen on the video of the incident, and gave explanations as to why he took the action he did with K.S. His anger was perceived as directed towards management, not K.S., as to the circumstances of the situation. He wishes to "clear his name" and not be perceived as one who abuses developmentally disabled individuals.

ALJ's LEGAL ANALYSIS AND CONCLUSIONS

The well settled policy of the State of New Jersey is to protect individuals with developmental disabilities. N.J.S.A. 30:6D-73. As part of its measures to protect such individuals, the New Jersey Legislature created the Central Registry to identify caregivers who have wrongfully injured individuals with developmental disabilities and to prevent such caregivers from working with such vulnerable individuals. N.J.S.A. 30:6D-73(a),30:6D-73(d); N.J.S.A. 30:6D-77; N.J.A.C. 10:44D-1.3.

An offending caregiver's name will be placed on the Central Registry if they are found to have abused or neglected an individual with developmental disabilities, and acted with the

requisite level of intent to cause or potentially cause injury. N.J.A.C. 10:44D-4.1; N.J.S.A. 30:6D-77(b).

Abuse is defined as "wrongfully inflicting or allowing to be inflicted physical abuse, sexual abuse, or verbal or psychological abuse or mistreatment by a caregiver upon an individual with a developmental disability." N.J.S.A. 30:6D-74; N.J.A.C. 10:44D-1.2. To be placed on the registry "in the case of a substantiated incident of abuse, the caregiver shall have acted with intent, recklessness, or careless disregard to cause or potentially cause injury to an individual with a developmental disability." N.J.S.A. 30:6D-77 b (1). In the situation of abuse, the statutes and regulations define the mental states of intent, recklessness, and careless disregard to cause or potentially cause injury to an individualwith a developmental disability as follows:

1. Acting intentionally is the mental resolution or determination to commit an act.
2. Acting recklessly is the creation of a substantial and unjustifiable risk of harm, to others by a conscious disregard for that risk.
3. Acting with careless disregard is the lack of reasonableness and prudence in doing what a person ought not do or not doing what ought to be done.

N.J.S.A. 30:6D-77(b); N.J.A.C. 10:44D-4.1(b).

The burden is upon DHS to establish, by a preponderance of the evidence, that petitioner's actions constituted abuse of K.S., thus requiring the listing of his name on the Central Registry. N.J.S.A. 30:6D-77(b); N.J.A.C. 10:44D-3.2; See, Atkinson v. Parsekian, 37 N.J. 143, 149 (1962); and Cumberland Farms, Inc. v. Moffett, 218 N.J. Super. 331, 341 (App.Div. 1987). Evidence is said to preponderate "if it establishes 'the reasonable probability of the fact.'" Jaeger v. Elizabethtown Consolidated Gas Co., 124 N.J.L. 420, 423 (Sup. Ct.1940) (citation omitted). The evidence must "be such as to lead a reasonably cautious mind to the given conclusion." Bornstein v. Metro. Bottling Co., 26 N.J. 263, 275 (1958).

Here, T.M. and T.H.J. are seen in the video pulling up in a vehicle adjacent to K.S., as he walked along the sidewalk of Delsea Drive, off the premises of the group home. T.M. and T.H.J. are out of the vehicle and T.M. is engaging in discussion with K.S., who initially backs away. K.S. then swings out throwing a punch at T.M. The video depicts that T.M. swings back at K.S. and after a brief moment of the two stepping away, K.S. begins backing up and T.M. shoves K.S. in the chest, pushes him backwards, and causes K.S. to stumble. T.M. aggressively moves in to bear hug K.S. and force him into the backseat of the car. K.S.'s inner right forearm is seen striking the door frame when he is shoved into the vehicle. T.M. admittedly pushed K.S. and placed him in a bear hug, in what he described was an effort to de-escalate the situation and get K.S. into the car to get him back to the home.

The photographs of K.S.'s arms and face, taken the following day, demonstrate bruising consistent with the force and physical interactions of T.M. with K.S. as seen on the video and as described by K.S. when interviewed by the police and by Investigator Gonzalez. The bruising is confirmed in the documentation from the emergency room and the Heart to Heart body check report. **The ALJ CONCLUDED** the testimony and evidence is consistent and preponderates that the bruising on K.S.'s face and inner forearms was caused by T.M.'s interaction with K.S. on September 1, 2019, when T.M. physically engaged with K.S. on the sidewalk and street side, pushing him, then placing him into a bear hug restraint and physically forcing K.S. through the rear passenger side door into the back seat of the vehicle.

T.M. was trained in how to prevent abuse. He was aware the Heart to Heart program was

a hands off program. He was never trained to physically engage or restrain any serviced client in the Heart to Heart program where K.S. resided. Although K.S. did swing his arm and threw the initial punch towards T.M., there is nothing seen on the video that K.S.'s initial act of aggression warranted T.M.'s actions thereafter. K.S. backed away. T.M. kept physically approaching and engaging K.S., admittedly pushing K.S. as a method of de-escalating him and getting him restrained into the car.

T.M. contends that K.S. was a substantial threat to him and to the community, due to K.S.'s behavior. T.M. asserted that K.S. was known to the police as a threat to the community, and that the police told management at Heart to Heart that they needed to find another placement for K.S. T.M. blames upper management of the home in failing to provide him proper assistance to care for K.S. Upper management was aware of K.S.'s escalating behaviors, and should have moved him out of the group home to a different program. The actions T.M. took during the incident were to protect himself and get the situation under his control. He asserts that what he did was no worse than what he had seen police officers do to K.S. He denied that he intended to harm K.S. Even if such information is true, it is no excuse to overcome the inappropriate physical interaction T.M. engaged in with K.S. by approaching K.S. and shoving him backward then grabbing him in a bear hug and forcing him into the vehicle.

T.M. asserted he was not intending to harm K.S. He thought he was de-escalating the situation. It has not been demonstrated that T.M. was acting intentionally, with malice and intent to cause harm to K.S. He was frustrated, as evident in his body gestures while interacting with K.S. before the physical interactions. He was set on getting K.S. back to the facility. His frustration with upper management was unmistakably expressed during the hearing. Such thoughts of frustration are visible in the video of his interaction with K.S. His use of force in shoving, pushing, and bear hugging K.S. forcibly into the car were done in what T.M. thought was an effort to de-escalate the situation. This choice of action by T.M. was done carelessly and zealously, in the heat of the moment. He was trained not to use physical restraints, yet did so. He was focused on getting K.S. back to the home. His poor choice of physical interaction caused the bruising injuries sustained by K.S. **The ALJ CONCLUDED** that T.M. wrongfully inflicted physical abuse upon K.S., having acted with careless disregard, lacking reasonableness and prudence, when he physically engaged in pushing, shoving, and bear hugging K.S. to forcibly get him into the vehicle.

The ALJ CONCLUDED that respondent, DHS, has demonstrated by a preponderance of the evidence, that T.M. acted carelessly by using physical force against K.S. resulting in bruising injuries, which is physical abuse of an individual with a developmental disability, as per the statutes and regulations. **The ALJ CONCLUDED** that T.M.'s name shall be listed on the Central Registry.

The ALJ's ORDER

The ALJ ORDERED that DHS's placement of T.M.'s name on the Central Registry of Offenders Against Individuals with Developmental Disabilities, for T.M. having engaged in physical abuse of an individual with a developmental disability, is **AFFIRMED**.

The ALJ FILED the Initial Decision with the **DIRECTOR OF THE OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY** for consideration, on August 9, 2023.

FINAL AGENCY DECISION

EXCEPTIONS

No exceptions were filed by either party.

DECISION

Pursuant to N.J.A.C. 1:1-18.1(f) and based upon a review of the ALJ's Initial Decision and the entirety of the OAL file, I concur with the Administrative Law Judge's findings and conclusions. The ALJ had the opportunity to assess the credibility and veracity of the witnesses; I defer to the ALJ's opinions concerning these matters, based upon the extremely detailed and well-reasoned observations described in the Initial Decision. I **CONCLUDE and AFFIRM** that the Department has met its burden of proving sufficiently that T.M.'s action's rise to the level of abuse; abuse is defined as "wrongfully inflicting or allowing to be inflicted physical abuse, sexual abuse, or verbal or psychological abuse or mistreatment by a caregiver upon an individual with a developmental disability." N.J.S.A. 30:6D-74; N.J.A.C. 10:44D-1.2. I **CONCLUDE and AFFIRM** that that T.M. acted with careless disregard, lacking reasonableness and prudence, when he physically engaged in pushing, shoving, and bear hugging K.S., an individual with developmental disabilities, to forcibly get him into the vehicle. I **CONCLUDE and AFFIRM** that T.M. acted recklessly, or with careless disregard to the well-being of an individual protected by N.J.S.A. 30:6D-73. I **CONCLUDE and AFFIRM** that T.M.'s placement on the Central Registry is appropriate.

Pursuant to N.J.A.C 1:1-18.6(d), it is the Final Decision of the Department of Human Services that **I ORDER** the placement of T.M.'s name on the Central Registry of Offenders Against Individuals with Developmental Disabilities, having committed the abusive acts of pushing, shoving, and bear hugging K.S, recklessly or with careless disregard for K.C.'s safety.

Date: September 12, 2023

Deborah Robinson

Deborah Robinson, Director
Office of Program Integrity and Accountability